

# APPLICATION AS CERTIFIED REEMPLOYMENT PROVIDER

PLEASE PRINT OR TYPE

## Provider Information

Name of Provider \_\_\_\_\_ How long has the firm been in business? \_\_\_\_\_  
(mo/yrs.)  
How long has the firm been in Utah? \_\_\_\_\_ (yrs)  
Utah Office Address \_\_\_\_\_ Telephone Number \_\_\_\_\_  
Name of Office Manager/Key Contact \_\_\_\_\_  
May we audit your billing statements? ☐ Yes ☐ No  
Parent Company (if applicable) \_\_\_\_\_  
Professional Liability Coverage ☐ Yes ☐ No Amount \_\_\_\_\_  
Carrier Name \_\_\_\_\_  
(Please provide copies of actual certificates)

## Utah Staff Information

Total Number of Staff \_\_\_\_\_  
Utah State Credentials \_\_\_\_\_  
☐ Certified Rehabilitation Counselor ☐ Certified Vocational Evaluator  
☐ Certification of Disability Management Specialist ☐ Certified Rehabilitation Registered Nurse  
☐ Masters Degree ☐ National Certified Counselor  
☐ Bachelors Degree ☐ Physical Therapist  
☐ Occupational Therapist ☐ Other  
Is ongoing education provided to the staff: ☐ Yes ☐ No

## Services Information

Please check resources and services  
☐ Vocational Counseling/Assessment ☐ Employer contacts ☐ Labor Market Survey  
☐ Resume Preparation ☐ Job Placement ☐ Worksite Assessment  
☐ Work Evaluation: ☐ Job Analysis ☐ Work Hardening  
\_\_\_\_\_ Physical Evaluation ☐ Aptitude Testing ☐ Other  
\_\_\_\_\_ Vocational Evaluation ☐ Ongoing Counseling for Long Term Support  
Has provider worked with Workers' Compensation ☐ Yes ☐ No Percentage Volume W/C \_\_\_\_\_  
Long Term Disability ☐ Yes ☐ No Percentage Volume LTD \_\_\_\_\_  
Medical Case Management ☐ Yes ☐ No  
Does the provider retain the services of a psychologist? ☐ Yes ☐ No  
If yes, Name \_\_\_\_\_  
Address \_\_\_\_\_  
Does the provider retain the services of a medical director? ☐ Yes ☐ No  
If yes, Name \_\_\_\_\_  
Address \_\_\_\_\_  
(Please provide an attachment if you need additional space.)



**Official Form 212**

**State of Utah • Labor Commission • Division of Industrial Accidents**

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Fax: (801) 530-6804 • Toll Free: (800) 530-5090 • [www.laborcommission.utah.gov](http://www.laborcommission.utah.gov)

What geological area is serviced? (Specify the counties)

Where are other office/staff located? (Specify cities, towns)

How are the cases assigned?

What methods are used to determine successful case outcomes? (Include your definition of success)

What is the provider's standard fee schedule?

Are there any flat fee services? ☐ Yes ☐ No Under what circumstances?

What is the breakdown of unit costs if different than flat rate for all services?

**Please provide two customer references for each Business Category.**

Vocational Counseling Assessment:

1. Name \_\_\_\_\_ Telephone Number \_\_\_\_\_  
2. Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Job Placement:

1. Name \_\_\_\_\_ Telephone Number \_\_\_\_\_  
2. Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Medical Management/Disability Management:

1. Name \_\_\_\_\_ Telephone Number \_\_\_\_\_  
2. Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Physical Rehabilitation:

1. Name \_\_\_\_\_ Telephone Number \_\_\_\_\_  
2. Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Other (Specify):

1. Name \_\_\_\_\_ Telephone Number \_\_\_\_\_  
2. Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Please provide the Reemployment Program with the following:

- a. A copy of official college transcripts for Vocational/Rehabilitation Counselors with B.S./M.S. degrees, or a copy of licenses for Nurses, Social Workers or Psychologists.
- b. Provider's Annual Report (audited financial report)

Date \_\_\_\_\_ Signature \_\_\_\_\_  
Name (please print) \_\_\_\_\_ Title \_\_\_\_\_